TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES

Final Rule
LSA Document #11-724(F)

DIGEST

Amends 405 IAC 1-1-2, 405 IAC 1.1-1-3, 405 IAC 2-10-5, and 405 IAC 9-5-2 to make administrative changes to the time limits and procedures for filing appeal requests by applicants or recipients. Amends 405 IAC 1.1-1-1 to update definitions. Amends 405 IAC 2-3-24 to specify the time limits and procedures for filing a hardship exception request. Effective 30 days after filing with the Publisher.

405 IAC 1-1-2; 405 IAC 1.1-1-1; 405 IAC 1.1-1-3; 405 IAC 2-3-24; 405 IAC 2-10-5; 405 IAC 9-5-2

SECTION 1. 405 IAC 1-1-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1-1-2 Choice of provider and use of Medicaid card

Authority: IC 12-13; IC 12-15
Affected: IC 12-13-2-3; IC 12-13-7-3; IC 12-15-12; IC 12-15-28-1

Sec. 2. (a) The recipient shall have free choice of providers for services provided in the state of Indiana and for services provided outside the state on an emergency basis, except as provided in subsections (b) through (c). Services to be provided outside the state, except for those out-of-state areas that have been designated by the office of Medicaid policy and planning (office), which are not of an emergency nature, require prior approval of the office.

(b) In the event the office implements a managed care program, the recipient shall select a managed care provider who is responsible for coordinating the recipient's health care needs. If a recipient fails to select a managed care provider within a reasonable time after being furnished a list of managed care providers by the office, the office shall assign a managed care provider to the recipient. A Medicaid recipient may not receive services from a provider other than the designated managed care provider except in the following cases:
(1) Medical emergencies.
(2) Where the managed care provider has authorized referral services in writing.
(3) Where specific services are excluded from coverage under the managed care program.
(4) Where specific services covered under the managed care program can be accessed through self-referral by recipients, as designated in IC 12-15-12 et seq.

(c) In the event that the office determines that a Medicaid recipient has utilized any Medicaid coverage service or supply at a frequency or amount not medically reasonable or necessary, the office may restrict the benefits available to the Medicaid recipient for a period of two (2) years by noting any restrictions on the face of the recipient's Medicaid card. The office may restrict the Medicaid recipient's benefits by:
(1) requiring that the recipient only receive benefits from the provider or providers noted on the Medicaid card, except as specifically approved in advance by the office; or
(2) prohibiting the recipient from receiving:
(A) any specific services noted on the card; or
(B) services from any specific provider or providers noted on the card.

(d) Not later than two (2) years after a Medicaid recipient's benefits have been restricted, the office will review the Medicaid recipient's case and continue the Medicaid recipient's restricted benefits if review of documented services indicates continued misutilization of Medicaid coverage services or supplies. The continued period of restriction will again be for a period of two (2) years, after which the Medicaid recipient's case will be reviewed and the restriction may again be renewed.

(e) A Medicaid recipient affected by the initial restriction under subsection (c) or continued restriction of benefits under subsection (d) may appeal the restrictions. Recipient appeal rights shall be those provided for in 42 CFR as required by IC 12-15-28-1, and the notice and hearing will be in accordance with the requirements of 42 CFR 431.200 et seq. and ~~470 IAC 1-4.~~ **405 IAC 1.1-1-3.**

(f) Before providing any Medicaid covered service, each Medicaid provider shall check the Medicaid card of the individual for whom the provider is performing the service. Failure to do so would result in denial of the provider's claim if the individual is not eligible or the service is not authorized. In checking the Medicaid card, the provider must determine all of the following:

(1) The Medicaid card is valid for the month in which the service is being provided.

(2) The individual whose name appears on the Medicaid card is the same individual for whom the service is being performed.

(3) No restriction or restrictions appearing on the Medicaid card would prohibit the provider from performing the requested service.

(Office of the Secretary of Family and Social Services; Title 5, Ch 1, Reg 5-102; filed Feb 10, 1978, 11:20 a.m.: Rules and Regs. 1979, p. 249; filed Oct 7, 1982, 3:50 p.m.: 5 IR 2344; filed May 22, 1987, 12:45 p.m.: 10 IR 2280, eff Jul 1, 1987; filed Aug 22, 1994, 10:00 a.m.: 18 IR 86; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Nov 4, 2011, 3:59 p.m.: 20111130-IR-405110318FRA; filed Feb 17, 2012, 10:42 a.m.: 20120314-IR-405110724FRA) NOTE: Transferred from the Division of Family and Children (470 IAC 5-1-2) to the Office of the Secretary of Family and Social Services (405 IAC 1-1-2) by P.L.9-1991, SECTION 131, effective January 1, 1992.

SECTION 2. 405 IAC 1.1-1-1 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1.1-1-1 Purpose

Authority: IC 12-8-6-5; IC 12-8-6-6; IC 12-15-1-10
Affected: IC 12-15-28

Sec. 1. (a) It is the purpose of this article to establish a uniform method of administrative adjudication for appeals concerning applicants and recipients of Medicaid, in order to determine whether or not any action complained of was done in accordance with federal and state statutes, regulations, rules, and policies. As used in this article, "policies" includes program manuals, administrative directives, transmittals, and other official written pronouncements of state or federal policy.

(b) This article shall be construed in such a manner as to provide all parties with an adequate opportunity to be heard in accordance with due process of law. As used in this article, "party" means:

(1) a person to whom the agency action is specifically directed;

(2) the office of Medicaid policy and planning; or

(3) the county office of **the division of** family ~~and children.~~ **resources.**

A contractor of the office of Medicaid policy and planning may act on behalf of the office for purposes of this article.

(c) In the event that any provision of this article is deemed to be in conflict with any other provision of federal or state statute, regulation, or rule that is specifically applicable to the Medicaid program, then such other statute, regulation, or rule shall supersede that part of this article in which the conflict is found.

(Office of the Secretary of Family and Social Services; 405 IAC 1.1-1-1; filed Jul 18, 1996, 3:00 p.m.: 19 IR 3377; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Feb 17, 2012, 10:42 a.m.: 20120314-IR-405110724FRA)

SECTION 3. 405 IAC 1.1-1-3 IS AMENDED TO READ AS FOLLOWS:

405 IAC 1.1-1-3 Filing an appeal; scheduling appeals

Authority: IC 12-8-6-5; IC 12-8-6-6; IC 12-15-1-10
Affected: IC 12-15-28

Sec. 3. (a) Any party complaining of ~~any~~ **an action by the** office of Medicaid policy and planning or ~~county office~~ **by the division** of family ~~and children~~ **resources** action in accordance with section 2 of this rule may file a

request for an administrative hearing as provided in this section.

(b) Unless otherwise provided for by statute, regulation, or rule, appeal requests by recipients or applicants shall be filed in writing with the ~~county office~~ **division** of family ~~and children, the state division of family and children,~~ **resources** or the **office of** hearings and appeals ~~section~~ of the family and social services administration **as provided in the notice of agency action. The appeal request must be received by close of business** not later than: ~~thirty (30)~~

(1) thirty-three (33) calendar days following the effective date of the action being appealed; **or**

(2) thirty-three (33) calendar days from the date of the notice of agency action;

whichever is later. Applicant and recipient appeal hearings shall be conducted at a reasonable time, place, and date.

(c) For purposes of this section, "close of business" means 4:30 p.m., local time, on the business day where the appeal is received. If the thirty-third day is a:

(1) Saturday;

(2) Sunday;

(3) state holiday; or

(4) day the office in which the act is to be done is closed during regular business hours;

the appeal must be received by the close of business the next business day. An appeal request received after close of business on the thirty-third day is untimely and invalid.

~~(c)~~ **(d)** A continuance of a hearing will be granted only for good cause shown. An objection to a request for a continuance shall be considered before a continuance is granted or denied. Requests for a continuance shall be in writing and accompanied by adequate documentation of the reasons for the request. Good cause includes the same factors as cause for a continuance in the Supplemental Security Income program (20 CFR 416.1436):

(1) inability to attend the hearing because of a serious physical or mental condition;

(2) incapacitating injury;

(3) death in the family;

(4) severe weather conditions making it impossible to travel to the hearing;

(5) unavailability of a witness and the evidence cannot be obtained otherwise; or

(6) other reason similar to those listed in this section.

If the appellant is represented by counsel, the request for continuance must also include alternative dates for the scheduling of a new hearing. However, the hearings and appeals section may schedule a new hearing without respect to the requested date if such date cannot be accommodated or confirmed with the requesting attorney within a reasonable time of the request.

~~(d)~~ **(e)** The **office of** hearings and appeals, ~~section of the family and social services administration,~~ upon application of any party, or in its own discretion, may consolidate appeals to promote administrative efficiency. Hearings and appeals may consolidate hearings only in cases in which the sole issue involved is one of federal or state law or policy.

~~(e)~~ **(f)** Any party filing an appeal under this article is not excused from exhausting all interim procedures that may be required by statute or rule for administrative review prior to the filing of an appeal. Any issues not preserved in a timely manner within the interim review procedures are waived and shall not be an issue during the evidentiary hearing.

~~(f)~~ **(g)** The **office of** hearings and appeals ~~section of the family and social services administration~~ will schedule evidentiary hearings and issue notices to the parties regarding the date, time, and location of the scheduled hearing.

(Office of the Secretary of Family and Social Services; 405 IAC 1.1-1-3; filed Jul 18, 1996, 3:00 p.m.: 19 IR 3378; readopted filed Jun 27, 2001, 9:40 a.m.: 24 IR 3822; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Feb 17, 2012, 10:42 a.m.: 20120314-IR-405110724FRA)

SECTION 4. 405 IAC 2-3-24 IS AMENDED TO READ AS FOLLOWS:

405 IAC 2-3-24 Undue hardship exception for Medicaid eligibility purposes

Authority: IC 12-13-7-3; IC 12-15-1-10
Affected: IC 12-15-2-10

Sec. 24. (a) At the time an applicant is notified that they are being denied Medicaid benefits due to:
(1) section 1.1 of this rule;
(2) section 22 of this rule; or
(3) both **sections 1.1 and 22 of this rule;**
the state shall notify the applicant that a hardship exception to the rules exists.

(b) An applicant may file for a hardship exception only if ~~they chose~~ **the applicant chooses** not to file for an administrative appeal on the merits of their determination. ~~The~~ **By** filing **a request** for a hardship exception, ~~shall serve as admittance by the~~ **an** applicant:
(1) admits that a transfer for less than adequate consideration was made and the agency's determination of any penalty was correct;
(2) waives the right to file a request for an administrative appeal; and
(3) revokes any previously filed administrative appeal.
If an applicant **simultaneously** files ~~for both~~ an administrative appeal and a hardship exception, the ~~application~~ **request** for the hardship exception will be **denied and** forwarded to the administrative law judge **for consideration.**

~~(b)~~ **(c)** The following persons can apply for the hardship exception and will have standing to pursue an appeal of denial of such exception:
(1) The applicant for benefits.
(2) The applicant's personal representative.
(3) The nursing facility in which the applicant currently resides, so long as the applicant or the applicant's personal representative consent.

~~(c) An applicant has~~ **(d) A request for a hardship exception must be received by the office of Medicaid policy and planning by close of business as defined in 405 IAC 1.1-1-3(c) not later than** thirty (30) **calendar** days from the date ~~they are~~ **the applicant is** notified ~~that they are denied~~ **of the denial of** Medicaid benefits under subsection (a). ~~to apply for the hardship exception.~~

~~(d)~~ **(e)** In order to qualify for a hardship exception, the recipient shall supply written documentation proving that the application of transfer of asset rules will deprive the applicant of:
(1) medical care such that the applicant's health would be endangered; or
(2) food, clothing, shelter, or other necessities of life.

~~(e)~~ **(f)** An undue hardship shall not exist when:
(1) the imposition of the transfer of assets provisions:
(A) merely cause the applicant inconvenience; or
(B) such imposition might restrict the applicant's lifestyle but not put the applicant at risk of serious deprivation;
(2) an individual is required to the sell an asset in an arms length transaction, which would result in a sale of the asset that is less than the current fair market value;
(3) the undoing of a transfer causes:
(A) adverse tax consequences; or
(B) penalties, interest, or other contract damages;
however where such penalties, interest, and contract damages are incurred in a contract between members of the same family (including step- and half- family members) the penalties, interest, and damages shall be considered transfers for inadequate consideration;
(4) applicant claims that:
(A) imposition of the transfer penalty will result in the dissolution of a marriage; or
(B) the only way to avoid the transfer penalty is to dissolve the marriage;
(5) the undoing of a transfer will cause hardship to an individual who is not the applicant.
This list shall not be exclusive, and the decision to deny an undue hardship exception shall not be limited to situations described in this subsection.

~~(f)~~ **(g)** The decision to grant or deny an undue hardship exception shall be made by the office within forty-five (45) days of receiving a request for an exception. Denial of an undue hardship exception under this section may be appealed by following the rules under ~~article 1.1 of this title.~~ **405 IAC 1.1.** An ALJ may only issue a hardship waiver when the denial of the hardship waiver by the office is being appealed.

(Office of the Secretary of Family and Social Services; 405 IAC 2-3-24; filed Aug 18, 2009, 11:33 a.m.: 20090916-IR-405080325FRA; filed Feb 17, 2012, 10:42 a.m.: 20120314-IR-405110724FRA)

SECTION 5. 405 IAC 2-10-5 IS AMENDED TO READ AS FOLLOWS:

405 IAC 2-10-5 Appeal

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-8.5
Affected: IC 12-15-3-6; IC 12-15-9

Sec. 5. (a) A recipient or his or her designee may, within ~~thirty (30)~~ **thirty-three (33)** days after receipt of notice described in this rule, request an administrative hearing under this rule.

(b) Administrative hearings and appeals by Medicaid recipients are governed by the procedures and time limits set out in 405 IAC 1.1.

~~(c)~~ Only one (1) appeal shall be afforded to a recipient, for each notice received in accordance with section 4 of this rule, notwithstanding the number of parcels owned by the recipient and identified in the notice.

(Office of the Secretary of Family and Social Services; 405 IAC 2-10-5; filed Dec 13, 2002, 4:00 p.m.: 26 IR 1548; readopted filed Sep 19, 2007, 12:16 p.m.: 20071010-IR-405070311RFA; filed Feb 17, 2012, 10:42 a.m.: 20120314-IR-405110724FRA)

SECTION 6. 405 IAC 9-5-2 IS AMENDED TO READ AS FOLLOWS:

405 IAC 9-5-2 Member grievances and appeals; insurers and association

Authority: IC 12-15-44.2-19
Affected: IC 12-15-44.2

Sec. 2. (a) A **plan** member dissatisfied with the action of an insurer must exhaust the insurer's internal grievance and appeals procedure prior to requesting a hearing by the state.

(b) The grievance and appeals procedures established by the insurers must comply with applicable state insurance laws and 42 CFR 438, Subpart F.

(c) After exhausting the insurer's internal grievance and appeals procedures, a member may file an appeal requesting a state hearing ~~thirty (30)~~ **thirty-three (33)** days from the date of the insurer's adverse notice of resolution. The appeal shall be governed by the procedures and time limits set forth in 405 IAC 1.1.

(d) The association shall have a grievance procedure that complies with 42 CFR 438, Subpart F. Appeals of actions taken by the association shall be governed by 405 IAC 1.1.

(Office of the Secretary of Family and Social Services; 405 IAC 9-5-2; filed Jun 16, 2008, 10:28 a.m.: 20080709-IR-405070648FRA; filed Feb 17, 2012, 10:42 a.m.: 20120314-IR-405110724FRA)

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